Governor's Committee on Problems of Aging

STATE OF MONTANA

REPORT

TO

THE HONORABLE TIM BABCOCK
GOVERNOR OF THE STATE OF MONTANA

November 1964

MEMBERS OF THE GOVERNORS' COMMITTEE

ON PROBLEMS OF AGING

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Secretary - Glenn O. Lockwood, Division of Vocational Rehabilitation, Helena

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Report of the Committee on

Problems of the Aging

INTRODUCTION

On April 24, 1962, Governor Tim Babcock announced the appointment of the Governor's Committee on Problems of the Aging. The following were appointed: Dr. A. Kearney Atkinson, 1220 Central Avenue, Great Falls; V. A. Burr, State Department of Public Welfare, Helena; Dr. George DeBelly, Box 235, Columbus; Dr. G. DeMartino, Montana State Hospital, Warm Springs; Lichfield J. Dorrington, Montana State Employment Service, Helena; Frank Dougherty, Elliston; Francis A. Howard, 822 North Rodney, Helena; Harry A. Westley, Buffalo Hill, Kalispell; Dr. James A. Shown, 312 Barber-Lydiard Building, Great Falls; Senator Kenneth Cole, Winnett; Ralph A. Jackson, Unemployment Compensation Commission, Helena; Glenn O. Lockwood, Bureau of Vocational Rehabilitation, Helena; Howard A. Johnson, First National Bank Building, Butte; Mrs. Don McLaughlin, 1950 Locust, Butte; John T. Plovanic, Montana Home for the Senile Aged, Lewistown; Mrs. Eleanor Redding, 1911 Aberdeen, Butte; John F. Sasek, Public Employees Retirement System, Helena.

Dr. James A. Shown was appointed temporary chairman to conduct the organizational meeting of the Committee on May 11, 1962. Dr. Shown had already completed arrangements to move to Salt Lake City so he resigned from the Committee at the first meeting.

Frank Dougherty, Secretary of the County Commissioners Association passed away shortly after the first meeting of the Committee. Neither Dr. Shown nor Mr. Dougherty was replaced on the Committee because it was felt the remaining fifteen Committee members constituted a representative Committee of sufficient size. In November 1963, Dr. G. DeMartino resigned from the Committee because he was leaving his position on the staff of the State Hospital at Warm Springs to practice in another state. Dr. M. F. Gracia, also of the staff of the State Hospital, was appointed as a member to succeed Dr. DeMartino. In June 1964, Ralph Jackson was succeeded as a member of the Committee by Curt Warner, also of the Unemployment Compensation Commission. The other thirteen original members of the Committee have continued to serve on the Committee throughout. Of the Committee members, four - Dr. Shown, Mr. Lockwood, Mr. Howard and Mr. Burr were members of the Montana Committee on Problems of the Aging which prepared for the state participation in the first White House Conference on Aging January 9 - 12, 1961.

Five members of the Committee, Dr. Shown, Mr. Howard, Mr. Burr, Mrs. Redding and Mr. Jackson were among the eleven state delegates to the White House Conference.

Approximately half of the Committee members are in state employment in one capacity or another and were selected for the Committee by virtue of experience and interest through this employment. The other half of the Committee members are not connected with government in an official capacity except through membership on the Committee. The distribution of interests and occupations of the whole Committee assures a cross sectional and widespread representation. The deliberations and evaluations of the Committee were enriched by the breadth of interests of the members.

In assigning responsibility to the Committee, Governor Babcock outlined

in broad guidelines what he expected. He authorized the Committee to determine its' field of activities and goals of achievement.

The Committee organized with the election of Mr. Burr as Chairman and Mr. Lockwood as Secretary. The Committee accepted responsibility to examine and evaluate problems of aging in a broad sense; to pursue certain aspects of the problems more specifically and to prepare a report to the Governor prior to January 1965. The Committee agreed to meet on the average of once each quarter.

The Committee could foresee that its work would be hampered unless some funds could be made available. Accordingly, the Executive Secretary to the Governor was asked to consider including in the appropriation to the Governor's office by the 1963 legislature, an amount that could be made available for use by the Committee. Such an appropriation would make it possible for the Committee to secure stationary, postage, pay for some travel and allow a Committee member to attend the annual conference on aging in Washington, D.C.

A sum of money was appropriated by the 1963 Legislature to the Governor's office, an amount sufficient not only for this Committee but also for other Committees responsible to the Governor's office.

From May 1962 through October 1964 the Committee met twelve times, an average of a meeting every two and a half months. The attendance of Committee members at each meeting averaged two-thirds of the membership, an outstanding achievement in itself in view of the fact that many members had to travel great distances to be in attendance.

In order to develop a report addressed to the Governor, the Committee resolved itself into several sub-committees, with assignments of segments of the report to the sub-committees. The several sections of the report are:

1. Housing Problems of the Aging.
2. Community Activities of Aging.
3. Legislation for a Statutory Committee on Problems of the Aging

4. Concessions to Aging.

5. Medical Problems of the Aging

HOUSING PROBLEMS OF AGING

The increasing complexity of contemporary life has led to the growth of congregate living for the aged in our society. The shift in population from rural to urban areas, the rapidly increasing life span, the advent of working mothers, the decline in family responsibilities for its elders, and the compulsory retirement from gainful employment at age sixty-five are contributing factors familiar to all. In past generations churches, other non-profit groups, and governmental units were able to provide facilities for the comparatively insignificant number of needy and homeless aged people. During the past two decades the upsurge in the "over 65" group of our population became critical, and their plight became the concern of the entire nation whose conscience was aroused by a concerted and sometimes exaggerated publicity campaign spearheaded by agencies of the federal government. As a result, facilities for aged are proliferating at an alarming rate and without any overall plan or direction to assure construction of facilities which meet the particular needs of a community and to discourage construction of unneeded and duplicating facilities. This entire problem should be the immediate concern of the state government if planned and orderly development is to supplant the growing chaos.

Long term care facilities in operation within the State of Montana in January 1964 were as follows:

	Number	Capacity
Licensed homes for aged - all types	88	1,615
County homes not subject to licensure	6	86
Unlicensed - operating under restraining court order	6	54
Skilled care nursing homes - licensed under hospital law	32	1,147
License pending	1	10
TOTALS	133	2,912
Homes ceasing operation	20	306

The following statistics supplied by the Division of Hospital Facilities of the State Board of Health indicate that the need for additional long-term care facilities vary greatly from community to community. (as of January 1964).

Percentage of Need Met = 100 per cent

Kalispell - Polson	Hot Springs
Shelby - Conrad	Lewistown
Great Falls	Dillon

Percentage of Need Met = 81 - 97 per cent

Miles City	Bozeman
Wolf Point - Poplar	Missoula

Percentage of Need Met = 61 - 80 per cent

Billings	Hamilton

Percentage of Need Met = 31 - 60 per cent

Butte	Cut Bank
Sidney - Glendive	Havre
Helena	Livingston - Big Timber

Percentage of Need Met = zero per cent

Libby	Roundup
Malta	Harlowton
Choteau	Ekalaka

(The "Percentage of Need Met" above is computed by subtracting the number of approved beds from the assumed need, which is arbitrarily derived as a percentage of the entire population. It should be noted that the above data do not take into account the concentration of elderly people in particular areas. Neither do they

indicate whether the type of facilities available in a given area are the type needed by its aged residents. No differentiation is made between institutions barely eligible for licensure and those of highest excellence.)

In our opinion, the State Board of Health and its staff are worthy of highest commendation for their efforts to upgrade the quality of facilities serving the aged in our state. We believe that the strict enforcement of licensing standards and that prior approval of building plans applied uniformly to all is in the best interest of society. If this is done, the spurious operator who now accepts patients at a price below the level at which proper care can be given will soon fall by the wayside.

Throughout our country a "boom" in the construction of facilities for the aged is in full flower. The magazine, Professional Nursing Home, reported in its September 1964 issue that 368 homes -- more than two a day -- were opened during the first six months of 1964. This phenomenon is nation wide. The President of the Illinois Nursing Home Association reports that in the Chicago area where private nursing homes with 3,000 beds have been built in the period of 1961-1963, some 2,000 beds were vacant. In metropolitan Denver during the past two years homes with approximately 1,750 new nursing beds have been built or are under construction. It is estimated that of the 3,866 approved beds, over twenty percent will be vacant. Similar examples could be cited from every section of the country, including the State of Montana.

Students of this problem fear that the over-supply of beds in the high cost bracket will drop the occupancy of existing and future nursing homes below the break-even point financially, and that many worthy and modest homes will be left overloaded with welfare and pension patients whose lower payments for care would no longer be offset by those able to pay higher rates. This situation cannot but lead to deterioration of services in the homes affected. Moreover, the proliferation of luxury facilities is such that in some areas there is danger of losing access to Hill-Burton funds for sorely needed skilled nursing care facilities. The chaotic

situation in which the industry finds itself today stems, to a large degree, from the easy credit supplied by federal agencies under regulations which prohibited until recently construction of anything except housing and personal care facilities, without regard for community needs.

The states of California and New York are in the process of establishing a franchise system to dispell the chaos developing within the homes-for-aging industry and to secure the orderly development of the types and number of facilities for aged needed in communities of their states. Under such a system, the prospective builder would be required to secure a permit from a public commission which would have authority to grant or deny the permit on the basis of its findings as to the need for the proposed facility in the particular community and the applicant's competence to finance and operate the facility at rates within the means of those he intends to serve.

The concept of regulation by permit from a state agency is relatively new as applied to sheltered care facilities. This type of regulation is not needed in Montana at this time but may be needed in the future unless there is some restraint in opening new facilities in certain areas in the state. It appears at this time that within the near future there will be an oversupply of sheltered care beds in some areas and an under-supply in others. It is hoped that, through the licensing and standard setting authority of the State Board of Health there can be a control that will prevent a mal-distribution of these facilities. It is in the public interest to develop a stable care-for-aging industry that will have reasonable assurance that it can operate at near capacity, earn a reasonable profit, and provide adequate and proper care at an acceptable price. The staggering economic burden to be placed upon society for the care of aged people in the future is such that we must act now to build the framework in which we can provide a maximum of service at a reasonable cost, without extravagant duplication and waste.

Most of Montana's institutionalized aged are cared for in proprietary homes, a fact which we believe will persist for sometime in the future. The raising of

minimum standards and the procurement of adequate funds to enable proprietary operators to live with these standards is a crucial problem which should be the concern of all responsible citizens. Montana needs its proprietary homes. However, we believe that non-profit homes provide the ideal setting for the care of the aged and that government should provide a climate facorable to their growth.

Determining the future course of care for the institutionalized aged requires that we recognize and fulfill certain basic physical, social and spiritual needs of the aged individual. Man as a social animal needs to identify himself with and to be a member of a group. He should not be categorized and placed in a specialized institution to be moved elsewhere as soon as we see fit to reclassify him. It is contrary to his nature and damaging to his well-being to uproot him from his friends and familiar environment. Thus, we envision a community-based, multi-purpose home, wherever economically feasible, which is prepared to care for the individual while he is reasonably healthy, as well as during his periods of chronic illness and senility. He would never be transferred from the home, except in unusual cases, but would be moved to specialized areas within the home as his condition requires, where he would remain in contact with his friends and be served by a competent and compassionate staff, who are interested in him as an individual with feelings and a soul.

COMMUNITY ACTIVITIES OF AGING

Education:

Elderly persons of retirement age wishing to improve their mental abilities or better their status in life should be given the opportunity to do so.

This could best be done by making available to them whatever school facilities the State of Montana or their own community can offer whether it be at the grade school, high school or university level. Should this not be possible or feasible, special classes in such courses as Art, Literature, Personal Development, etc. could be instituted in some schools.

Many elderly people who previously have not had the time or opportunity to take advantage of such educational facilities would be attracted to such classes.

Hobbies:

This is one field where the state and the community could be very helpful to our older citizens. Senior Centers, if they would be so called, could be established in most of the cities in the State of Montana. These Senior Centers could be the focal points of activity for the aged. Arts and crafts of many varieties could be taught in such centers.

Here again, the community would have to be called on to bear the biggest share of the burden in creating such a center, and also in keeping it in operation and functioning properly. The State of Montana should be in some manner able to help the communities, especially with the organization of such centers.

Because the need for human fulfillment is evident in every person regardless of age, the Senior Citizen Centers are a proven ground for activities appropriate to the aging persons. Many of these centers provide continual activities, both active and passive, cultural and mechanical for the benefit of Senior Citizens. Usually management of the centers is undertaken by the Senior Citizens themselves. Such groups are active in several cities in the state (e.g. in Butte there is a club with more than 250 members).

In communities where Senior Centers are not practical, night hobby classes in some arts and crafts could be instituted in either Junior or Senior High Schools.

Let us be mindful of what Mr. Garson Meyer, President of the National Council on the Aging recently stated - "Unfortunately we are still living in a period of cultural lag, in which concern for our older citizens is not of paramount interest to most people. It is not only necessary to overcome the apathy which usually exists in dealing with social problems generally, but there is good reason to believe that in planning for older people's welfare there is even much deep-rooted resistance."

Part-time employment:

Some of the older citizens of the State of Montana who should be completely retired, as far as being gainfully employed is concerned, cannot do so. This is due to the fact that their retirement income is insufficient even for normal living expenses.

Some of these people, who though they are 65 years of age or older, have been, and still are capable of doing at least a good part-time job. Persons with such meager retirement incomes, who are mentally and physically able, should be given an opportunity to supplement these incomes. Most old people feel that the only honorable way to achieve financial gain is to work for it.

Not only would this part-time employment aid these older people financially, but being occupied would tend to help them keep in better physical condition and more mentally alert. Also in the same manner, it would help keep them away from the old concept of aging, namely, a process of deterioration and decay, and tersely characterized as chronic brain syndrome.

It would be well for all of the citizens of the State of Montana to remember that it is their obligation to see to it that our older people are helped to live out their remaining years with dignity, purpose and meaning.

LEGISLATION FOR STATUTORY COMMITTEE ON AGING

State agencies on aging exist in forty of the fifty states. The variety of names for these councils, commissions and committees is such that it is difficult to find two designations alike. However, the patterns of operation of the agencies fall into several well defined groups. Twenty-one of the agencies have full-time paid executive directors, with clearly designated operating functions. Five have part-time paid executive secretaries with functions varying from clearly designated operating to advisory or evaluatory. The other fourteen are committee type which function in an advisory or evaluatory capacity.

Of the forty state agencies, twenty-six have been established by legislative action with the other fourteen established by administrative action, usually designation by the Governor.

From another viewpoint of evaluation, three patterns of state aging organizations are apparent. Some of the state agencies are independent units, some function within an existing department of state government, while others are advisory units under the office of the Governor. Of course, there are arguments both in favor of and against all three organizational patterns. The validity of many of the pro and con arguments exists because of the fact that the state is "big" or "small".

This Committee has looked into the points in favor of and against the three organizational patterns and has evaluated them in relation to Montana. The variety and extent of problems of aging in this state do not at this time warrant an independent agency. Several existing state agencies do have programs which offer services to the aging and aged. Because nearly ten percent of the total population of Montana is composed of persons 65 and over, and is increasing, the whole problem of aging should have special attention. Perhaps the best way in which this special attention might be acknowledged would be through continuation of a Committee on Problems of the Aging.

The development of understanding and a fund of knowledge of the many facets of problems of aging come from a continuity of effort over a period of time during which committee members function and learn. Successive different committees acquire bits of information and knowledge but fail to achieve the cumulative total fund of information and knowledge available to a committee which has the continuity that can come through overlapping terms of members of a committee. Five succeeding committees serving two years each end up with five separate accumulations of two years of knowledge. One committee with overlapping terms ends up with a ten year accumulation in the same period of time.

Continuity of a committee is not assured when it is appointed on a voluntary basis by a Governor or other state authority. Continuity is assured to a much

greater extent when the appointment must be made in compliance with a statutory requirement. The national experience in this has been that committees, when appointed voluntarily, have a history of existence and non-existence over a period of time. The states which have agencies or committees appointed by legislated requirement show a continuity of existence through the years.

Problems of aging have no political affiliations. The committee which is truly non-partisan in its total operations has the objectivity necessary to work with such problems. Committee members appointed solely because of their interests and accomplishments in the field of aging will have greater success than a group appointed because of political leanings. It is the recommendation of this committee that a bill be introduced in the 1965 legislative session which would authorize the Governor to appoint a Committee on Problems of Aging. It should be selected on a non-partisan political basis with stated overlapping terms for members.

CONCESSIONS TO AGING

While some concessions have been initiated by certain types of businesses, and by certain business establishments, such as discounts for drugs and for admission to moving picture theatres, it seems preferable to limit our discussion to concessions by the public, i.e., by state and federal governments.

We now have concessions under income tax laws for those who have attained the age of 65 years. These take the form of an extra $600 personal exemption under both federal and Montana State income tax laws. A like exemption is allowed also if the taxpayer is totally blind, thus providing three exemptions or $1800 for both blindness and age. These exemptions apply to both husband and wife, so that if both are above the age of 65 they have four exemptions totalling $2400 with still a further exemption if one of them is blind.

These concessions are of special importance in view of a half century's history of increasing tax rates and decreasing personal exemptions since the inception of

of federal income taxes in 1913, with only slight and temporary relief measures during those two generations of taxpayers. A brief analysis of the subject seems warranted.

Personal exemptions were originally designed to afford basic subsistence allowances for the taxpayer and his family before tax liability. But that purpose has been largely defeated, not only by the reduction of exemptions through legislative action, but even more by the reduction of their purchasing power through inflation, which has cut down the dollar's real value at least one-half in twenty-five years and at least two-thirds in fifty years, with no hope of reversing the trend.

In 1924 the federal exemption was $1000 for the individual taxpayer and $2500 for a married couple. In 1926, after a substantial reduction of World War I debts, these exemptions were increased to $1500 and $3500. But that relief was only temporary; in 1932 these exemptions were returned to $1000 and $2500; in 1940 they were reduced to $800 and $2000 and in 1942 5o $500 and $1200 thus making them only about one-half what they were in 1924 and one-third what they temporarily were from 1926 to 1932.

In 1945 the exemption was made $500 for each person including minor dependents which had theretofore been $400. In 1954 it was raised to $600 for each and new $600 exemptions were added for the aging and the blind. Thus in 1954 the exemption for the aging individual was raised from $500 to $1200 and for the aging married couple from $1000 to $2400 or 140%. As one isolated act this seems a very substantial reduction. But as noted above, from 1926 to 1932 the exemptions were $1500 for all individuals and $3500 for all married couples; and even from 1934 to 1940 they were $1000 and $2500 respectively.

In other words, for the aging couple, the present exemption in dollars is about 31% less than in 1926, and 4% less than in 1932; and since the purchasing power of the dollar has dropped to about one-third of what it was in those years, the aging have still lost at least two-thirds of their exemption values. In this respect the

aging are, of course, twice as well off as those without the extra exemption, which means that the differential is not likely to be increased, and that the only further relief can come through reduced government expenses and, therefore, reduced taxes for everyone.

There can be no doubt that these historically steady increases in tax burdens and reductions in personal exemptions through inflation and statute have been due largely to federal government policies during most of the past half century. State governments, not being able to print money and bonds virtually without limit, have contributed much less to the inflation, although their expenditures also have increased.

Montana income tax statutes have also provided an extra exemption at age 65, although at the same time cutting the size of each exemption and raising tax rates.

In this connection it should be noted that until 1957 the state income tax exemptions for husband and wife were $1000 for each. In that year the legislature added exemptions for the blind and the aging, but cut each exemption from $1000 to $600 except for minor dependents, which it increased from $300 to $600. Thus, the exemptions for a middle aged couple without dependents were cut from $2000 to $1200; and those for an aging individual were raised only from $1000 to $1200.

The income tax rates had ranged from 1% to 4% in three $2000 brackets of 1%, 2% and 3%, with the 4% rate upon taxable net income above $6000. But the same legislature reset the rates at from 1% to 5% in seven $1000 brackets of 1%, 1½%, 2%, 2½%, 3%, 3½% and 4%, with the 5% rate on taxable net income above $7000. At these rates the tax saving on the extra $200 exemption amounts to from $2.00 to $10.00, which is hardly munificent. It is improbable that many of the unemployed aging get within either the 4% or the 5% bracket, but any saving may be at least partly nullified by higher taxes on remaining income. Under the new rates the additional tax is $5.00 on a $2000 taxable income and $10.00 on $4000.

Thus, neither of the new federal and state exemptions actually gave very much to the aging, although they did afford relief from some of the extra burdens at

the same time imposed on everyone else through the concurrent changes.

The reduction in federal income taxes under the 1964 tax law will give some additional relief while it lasts, but is relatively slight.

There are some statutory concessions in Montana according to age, mostly of long standing, and none of much actual value. For instance we have for many years had county poll taxes in Montana, not as prequisites for voting, but for road and poor tax purposes. Our code section 84-4732 authorizes an annual poll tax not exceeding $3.00 on all able bodied male inhabitants of cities and towns between the ages of 21 and 45 years. Section 32-201 provides for a county poll tax of $2.00 per annum on each male citizen between 21 and 50 years of age living within the county, but excepting those who are taxed under section 84-4732 as inhabitants of a city or town. Section 71-106 empowers county commissioners to levy a poor tax of $2.00 upon all residents of their county between the ages of 21 and 60 years, together with a tax on their property not exceeding 3/5th of 1%. By a recent amendment this tax may, under certain circumstances be increased to 17 mills.

The only recent concession according to age is an amendment of section 26-202.1 adopted by the 1963 Legislature entitling any Montana resident who has attained the age of 70 to fish without the ordinary $3.00 Class A fishing license, "provided that said persons carry proof of age *** in lieu of the Class A license". Strictly interpreted, the provision exempts not all persons above the age of 70, but only those above that age who carry with them proof of their age. This limitation should be fully understood, since strictly a person 70 years of age found fishing without a license would not be entitled to the exemption by merely proving his age in court.

A number of states provide tax relief for home owners attaing the age of sixty-five years. This relief varies, but is properly limited to definite valuations, so as to give relief where most needed, without requiring a showing of actual need. Any tax exemption transfers some burden to property which is not exempt, including the non-exempt property of the aging as well as the property of all other tax payers.

Therefore, any exemption statute should provide a definite limit; but the limit should not be so low as to afford little relief to those who actually need it.

One objection to such concessions is that they help only home owners and not renters, who also should be aided to maintain homes of their own. This objection has been met in Wisconsin by means of an income tax exemption for property taxes or rentals paid on residence property. The computation is somewhat complicated. First is shown the total property tax paid on the residence property, or 25% of the rentals paid, in either case not exceeding $300. From this figure is deducted 5% of income up to $2000 and 20% of income over $2000. The proportion of the remainder then allowed as a tax exemption is 75% if the total income was less than $1000, or 50% if it was $1000 or more. Thus, assuming that the property tax, or one-fourth of the rentals, amounted to $300 and that the income was $2000, 5% of the latter, or $100, would be deducted from $300 leaving a remainder of $200; and 50% of the latter, or $100, would be allowed as a credit. Assuming that the income was only $900, 5% of that amount, or $45, would be deducted from the $300, leaving $255; and 75% of the latter amount, or $191.25, would be the credit. Again, assuming that the income was $3000, the deduction from the $300 would amount to 5% of the $2000 or $100, plus 20% of $1000, or $200, leaving no remainder for the credit. Thus, the credit is limited to persons with incomes less than $3000.

These complications seem unnecessarily involved but undoubtedly resulted from practical considerations. Some such credit might well be considered for Montana in order to assist the aging to remain in their accustomed homes, whether rented or owned.

MEDICAL PROBLEMS OF AGING

In dealing with the problem of the aging individual and the mental difficulties that he or she encounters in that process, we find that a person who lives a long life is bound to find himself with the fact that other members of his family, community, or immediate environment are going to fade away through death, moving away, etc., and consequently, isolation is the result. To this isolation the individual, because of the many years of sharing common interests, ambitions, happiness, sorrow, making and forming strong family ties and friendships, that are so important a part of any human relationship and experience react with sadness that usually is the superficial manifestation of depression, that can be deeply settled in the individual to the point of needing medical attention and care.

Also, in the process of aging, the person goes into the metabolic changes, that our anatomy and physiology endure with the coming of the years, that eventually are going to manifest a marked difference in the capacity for work and play, handicapping the individual for any kind of favorable competition with the younger members of society. These evident changes in behavior, memory, attitudes, and the appearing of organic or physical ailments are characteristic and typical of the elderly individual. Some of these changes in behavior, thinking process, emotional capacity, memorizing ability, reflex action, are going to be manifest in the sense of diminution of abilities, being detrimental to the well being of the individual, and creating feelings of inferiority, aggravating any depressive mood, creating also the need for medical attention. In the extreme examples of these changes produced by the aging process, the individual can become a mental patient in an institution, specializing in the care of that kind of ailments, and it is in this condition that we see the elderly admitted to psychiatric institutions.

The elderly person newly admitted to a mental institution shows two kinds of clinical manifestations, the reversible and irreversible conditions, and these can be subdivided into organic or physical ailments, and the pure mental or emotional manifestations.

Basically behind many of the emotional factors involved in the clinical manifestations found in the mentally ill elderly person, separation, is one of the most important elements. And in explaining the statement, we can say in a broad sense, separation from family, friends, community, old habits and customs, the individual feels the uselessness of his life. In the elderly person suffering with some mental condition accompanied with symptoms of psychosis, ideas of persecution, loss of contact with reality, delusions, or hallucinations, he is going to find himself in a cloudy state, that makes him unaware of some emotional experiences. Any of those cases will need a protected environment, medical treatment, drugs, nursing care, counselling, etc., but in many cases those are not the ultimate goals that ought to be desired. The mentally ill, young or old, belong in the community, once the patient is ready to live outside the hospital environment.

Applying some of the stated concepts and ideas to the problem of the aged in Montana, we find that at the Montana State Hospital in Warm Springs, there are about 1500 patients. One third of this population is composed of individuals over the age of 60 years. Of this number we find a division into the newly admitted elderly persons and the chronic, long standing patients in the institution. The latter group fall in the category of the above mentioned patients with lack of family contacts, social deprivation, etc., suffering from long term hospitalization, with poor social contact with the outside world. They offer a great challenge to the staff personnel, in regard to rehabilitation or replacement in situations outside of the institution, if their recovery from mental illness allows this. For the firsg group, the newly admitted elderly persons with some kind of emotional or mental disturbance, who recover soon if the family or community ties are not severed, the chances for rehabilitation are higher.

Lately at the Montana State Hospital, there has been an increase of that type of admissions, i.e., elderly citizens suffering with different ailments, physical or mental, some without a great need for psychiatric care, but due to the lack of facilities in the counties of residence they are placed at the State Hospital. On

the other hand, this type of patient takes the space of the psychiatric beds and the hospital functions in this instance as another nursing home, with better nursing and medical care.

As a help in the solution of some of these problems we can follow the many national studies and recommendations in these areas to increase the interest of the communities in the problems of the aged. This would include private citizens, doctors, social workers, lawyers, civic leaders, etc., that can contribute with their organized efforts to alleviate the needs of the senior citizens.

Among those needs is the creation of social contacts with the elderly to help in the financial support and recreation, to look for adequate activities that the old can do and must do when capable. The idea of the rocking chair is still good for the very old or tired individual but not for a great majority of the average old individuals. At this point the need for being accepted and being useful is fulfilled. This has a great impact in the personality make-up of the old giving satisfaction and a sense of well being so important in the later years of life, with a significant psychological value.

The improvement of living conditions, physical plants, clothing, food, recreational activities, hobbies, social participation, use of leisure time, sense of being useful, all of which have a great psychological value in helping to prevent depression, a sense of inferiority and self-depreciation that some times can be linked to suicidal attempts, or excessive use of alcohol, or other changes in behavior detrimental to the individual and the community at large.

Indifference to the environment, lack of drives, no interest in life in general are the symptoms of social deprivation, depression and dissatisfaction that are behind the creation or aggravation of many cases of mental illness in the elderly person. All those individuals and organizations already mentioned can help in preventing many of those factors that have a negative influence on the older individual and as a result can make their lives happier and healthier.

This points to the fact that it is better to prevent than to cure in the

elderly some of the manifestations of mental illness because of the lesser resistance to psychological trauma. On the other hand some elderly patients make a remarkably good adjustment to the hospital life.

The creation of special geriatric services in general hospitals on an out-patient service can do a lot to prevent and cure in the early stages many of the manifestations that, later on, could crystallize in a frank psychosis. Visiting nurses and social workers especially in the more populated areas could help to detect poor hygienic and sanitary conditions detrimental to the mental health of the elderly persons that can create metabolic conditions, possibly combined with excessive drinking resulting in mental disorders.

Older patients average 7.9 visits to doctors in 1964.

In the course of the current year, Americans over 65 years of age will make 148 million calls on physicians for consultation, examination, diagnosis or advice. These patients will average 7.9 visits to doctors, in comparison with an average of 5.6 visits by the general population, regardless of age.

"There is a tendency among the aging to seek medical treatment or advice more frequently due to the occurrence of one or more chronic conditions", a study conducted by Geriatrics Magazine states. The leading chronic diseases cited are arthritis, hypertension, arteriosclerosis, and diabetes.

Naturally, these visits will not be distributed uniformly. Many elderly persons will not consult a physician at all this year; others may see him 50 or more times.

General practitioners will be consulted in 53 percent of geriatric patient calls, internists in another 12 percent, the study indicates. Other specialists seen most frequently are surgeons, eye, ear, nose and throat men, osteopaths, urologists, orthopedists and dermatologists.

Nearly 25 percent of all medical consultations by older patients are in connection with diseases of the circulatory system. Other leading ailments requiring

frequent medical attention are diseases of the nervous system (11.4 percent), diseases of the bones and organs of movement (8.1 percent), diseases of the digestive system (7.4 percent), neoplasms (7.1 percent), diseases of the genito-urinary and respiratory systems (6.8 percent each) and accidents, poisoning and violence (6.6 percent each).

County responsibility.

In this state the responsibility of meeting the medical and hospital needs of those unable to provide for their own, rests with the County Board of Commissioners, acting as Commissioners or as Boards of Public Welfare. This responsibility has a tradition that goes back to the early days of the state, stemming from the constitution of the state. When the Public Welfare Act was adopted by the 1937 Legislature, the responsibility on the part of County Commissioners was reaffirmed in the act. No substantial change has been made by any succeeding legislature.

However, practice in meeting the responsibility by County Commissioners has undergone a continual evolution to meet changing circumstances and changing demands through the years. In earlier years medical needs of the fully indigent were met primarily through the facilities of the old Poor Farm and through contract arrangements with a single doctor and a single hospital in the county. With the passage of the Social Security Act on August 14, 1935 change came about with stepped up rapidity. National as well as state and local understanding of the "indigent" changed sharply, whereas previous to this time the terms "indigent" and "pauper" were quite interchangeable. Under the several titles of the Social Security Act the so-called paupers oath was abandoned in connection with the receipt of public assistance. Need became a term of relative amount related to providing a common floor of aid to all who needed help, including those who could meet part of their own subsistence needs but not all.

Gradually a certain dignity became attached to the receipt of assistance. Along with these developments came the obvious conclusion that one of the common reasons

behind inability to provide for his own subsistence needs was the physical poor health of many people. Any inventory of the assets and lack of assets of people inevitably brought out the predominance of health problems. For so many years those in the low and very low income groups let health problems go unattended, primarily because of the difficulty of getting medical care through the established channels.

As health problems were identified more and more as the underlying cause of inability to continue self-support, attention was given to seeking more medical care for more people in order to prevent the stock-piling of greater numbers of disabled people and to rehabilitate others whose disabilities were not too severe. County commissioners gradually changed their thinking on the whole problem and to the extent possible, in 56 counties, each differing somewhat from the others, provided more and better medical care.

Gradually the contract system was replaced with agreements entered into with several or all of the doctors of a county and with all of the hospitals. The Poor Farm system dwindled so that by 1945 nearly every one was eliminated, with most replaced by nursing home facilities, either county owned or operated or in proprietary homes with the care purchased by the county.

The slow but gradual improvement of medical services has continued to this day. Medical services provided by County Commissioners now range from quite inadequate in some counties to adequate in others. It can be expected that uniform adequate medical care cannot be achieved in 56 counties each acting as separate entities. The reasons for this are rather obvious; differing attitudes of County Commissioners and local citizenry, differing abilities among counties to raise sufficient monies from local tax bases, lack of even the most basic medical facilities in some counties, the increasing need of medical facilities because of the increase in life span of older people, among many other reasons.

The great problem that now arises to compound the problems of County Commissioners in providing medical care is the increase in costs. During the

fiscal year July 1, 1963 through June 30, 1964 the 56 counties spent $4,317,680 for medical care. For many years this cost has increased by a quarter of a million dollars a year. In many counties much more than one-half of all poor fund money goes for medical care.

County Commissioners themselves have not as yet given support to any plan that would share this cost by bringing in state and federal money. Since by law the provision of medical care to the needy is the responsibility of County Commissioners they should take a role of leadership if they wish the responsibility to be shared or to pass from them. Until such time as County Commissioners ask for help in this whole area of medical care, it is the conclusion of this committee that no recommendation can at this time be made to suggest a sharing of costs.

Joint cost survey.

In an effort to learn more about how the medical care of the people of Montana is financed, the joint hospital and medical committees of the Montana Medical Association and the Montana Hospital Association surveyed the cost of patients hospitalized during the month of May 1964. The following is a summary of the preliminary report to September 1, 1964. This shows the percentage of the bills paid between May and September.

PHYSICIANS SURVEY	0-18	19-30	31-40	41-65	over 65
Number of Patients	490	387	297	666	426
Percentage of account paid	64.6%	59.7%	64.3%	72.0%	81.0%
HOSPITAL SURVEY					
Number of Patients	1110	846	581	1240	782
Percentage of account paid	60.2%	57.3%	63.0%	65.0%	69.7%

Of the 2256 beds in the entire hospital association survey, the replies are based on 1310 beds. Replies were received from 13 of the participating 22 hospitals. The preliminary report from the physicians in the survey constitute replies from 129 physicians out of the total of 167 physicians participating in the survey.

A recent survey of several large hospitals in Montana show that the overall collection percentage exceeds 90%. It also shows that the collection percentage in the over 65 age group exceeds 90%.

From this survey it is obvious that the younger age groups require the most time to pay their hospital expenses and the majority of the over 65 age group in Montana who are hospitalized can meet their hospital expenses.